



# MDS 3.0 Section M: Skin Conditions

Presented by

Jeri Ann Lundgren, RN, BSN, PHN, CWS, CWCN, CPT

President

Senior Providers Resource



---

---

---

---

---

---

---

---

## MDS 3.0



Starts with an accurate assessment of:

- Risk factors
- Etiology of the ulcer
- Assessment of the ulcer

---

---

---

---

---

---

---

---



www.seniorprovidersresource.com

## The New Terminology and the MDS



- National Pressure Ulcer Advisory Panel (NPUAP) Updated Terminology and definitions April 2016
- NPUAP Definition August 2016 Press Release:
- “CMS has been in discussions with the NPUAP to incorporate the new terminology. The rollout of the changes will be controlled by these agencies”
- Continue to follow MDS instructions – providers may continue previous definitions to fit MDS terminology or they may adapt the new terminology. Essentially the stages are the same just clarified definitions.

---

---

---

---

---

---

---

---



www.seniorprovidersresource.com



### The Definition of Pressure Injuries

**• National Pressure Ulcer Advisory Panel (NPUAP)  
Definition April 2016:**

- A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---



### The Definition of Medical Device Related Pressure Injury

**• National Pressure Ulcer Advisory Panel (NPUAP)  
Definition April 2016:**

- This describes the etiology of the injury. Medical device related pressure injuries result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the pattern or shape of the device. The injury should be staged using the staging system.



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---



### The Definition of Mucosal Membrane Pressure Injury

**• National Pressure Ulcer Advisory Panel (NPUAP)  
Definition April 2016:**

- Mucosal membrane pressure injury is found on mucous membranes with a history of a medical device in use at the location of the injury. Due to the anatomy of the tissue these injuries cannot be staged



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---



### The Etiology of Pressure Injuries

- The duration of time for which tissue cells can endure the ischemia without damage differ for muscle, fat, and skin. Muscle tissues are more susceptible to damage than skin tissues.
- Skin is much stiffer than muscle and fat therefore deforms to a lesser degree in most clinical applications
  - NPUAP, 2014, p.21

---

---

---

---

---

---

---

---

---

---



www.seniorprovidersresource.com



### Pressure Injuries



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---



### The Etiology of Pressure Injuries

- Lower thresholds of pressure and deformation can take a longer period of time before tissue damage occurs
- Higher pressure and deformation strains at higher than 50% will almost immediately (within minutes) lead to tissue damage at the microscopic scale.
- Reperfusion that follows a period of prolonged ischemia may increase the degree of tissue damage because it involves release of harmful oxygen free radicals
  - NPUAP, 2014, p.21

---

---

---

---

---

---

---

---

---

---



www.seniorprovidersresource.com

### Contributing factors: Microclimate



• An increasing body of evidence suggests that the microclimate between skin and the supporting surface plays a role in the development of Stage 1 and 2 pressure injuries (NPUAP, 2014, p.21)

- Microclimate is the humidity and temperature
- Increased humidity and temperature can cause the skin to become weaker and less stiff
- Excessively dry skin becomes more brittle and liable to break



www.seniorprovidersresource.com

---

---

---

---

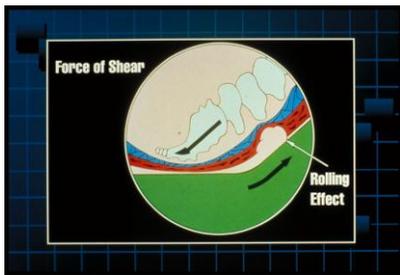
---

---

---

---

### Contributing Factors: Shear (deformation of tissue)



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

### Contributing Factors: Shear (deformation of tissue)



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

## Moisture Associated Skin Damage (MASD), Secondary to incontinence or perspiration is NOT a pressure injury



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

## Section M



### • M0100: Determination of PU Risk

#### • Steps for Assessment

- Review medical record (Skin care flow sheets/tracking forms, Nurse's notes & Risk assessments)
- Speak with the treatment nurse and direct care staff on ALL shifts for confirmation
- Examine the resident and determine whether any ulcers, scars, or non-removable dressings/devices are present. Also assess bony prominences & under braces, etc.



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

## Risk Assessment



### • Skin inspection

- Upon admission, re-admission
- Daily with cares
- Weekly by licensed staff
- Upon a planned discharge



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

## Risk Assessment



### • Comprehensive risk assessment

- Upon admission/re-admission
- Weekly for the first 4 weeks after admission
- Change of condition (decline in mobility, cognition, incontinence, nutritional compromise)
- Quarterly/annually with MDS

---

---

---

---

---

---

---

---

---

---



www.seniorprovidersresource.com

## Assessment



### • When a pressure injury is present, daily monitoring should include:

- An evaluation of the wound, if no dressing present
- An evaluation of the status of the dressing, if present
- The presence of complications
- Whether pain, if present, is being adequately controlled




---

---

---

---

---

---

---

---

---

---



www.seniorprovidersresource.com

## Assessment



### • Wounds should be assessed/documented at least every 7 days

- More frequently if:
  - Complications or
  - Per dressing change

• A clean pressure injury with adequate blood supply & innervation should show evidence of stabilization or some healing within 2-4 weeks.

• Nurse Notes should reflect progress of wound only.




---

---

---

---

---

---

---

---

---

---



www.seniorprovidersresource.com

## Assessment



### • GOAL of Assessment:

- To determine the progress of the wound
- To determine the appropriate topical management and overall interventions



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

## Wound Bed Assessment



### • Describe the tissue in the wound bed using professional terms

- Necrotic/eschar
- Slough
- Granulation
- Epithelial



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

## Wound Bed Assessment



### • Necrotic/eschar tissue – black, brown, or tan tissue



www.seniorprovidersresource.com

---

---

---

---

---

---

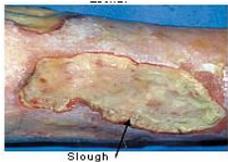
---

---

## Wound Bed Assessment



- **Slough** – yellow or white tissue that adheres to the wound bed in strings or thick clumps, or is mucinous



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

## Wound Bed Assessment



- **Granulation** – pink or beefy red tissue with a shiny, moist, granular appearance



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

## Wound Bed Assessment



- **Epithelial Tissue** – New skin that is light pink and shiny even in darkly pigmented skin



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

## Wound Bed Assessment



• Describe the tissue present in the wound bed using percentages:

- 10% slough tissue, 90% granulation
- Should equal 100%!!!!!!



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---

## Staging Pressure Injuries



### The NPUAP Staging System for Pressure Injuries ONLY



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---

## Stage 1 Pressure Injury



• Stage 1 Pressure Injury: Non-blanchable erythema of intact skin

- Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.



www.seniorprovidersresource.com

---

---

---

---

---

---

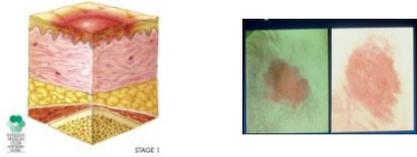
---

---

---

---

### Stage 1 Appearance



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

### Deep Tissue Injury



#### • Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration

• Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3, or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

### Deep Tissue Injury



• Internal stresses and strains adjacent to bony prominences are substantially higher than those near the surface, and have the potential to cause damage in deep tissues before the superficial tissue is damaged (NPUAP, 2014, p.20)



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

### Deep Tissue Injury



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

### Evolution of a Deep Tissue Pressure Injury



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

### Evolution of a Deep Tissue Pressure Injury



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

## Stage 2 Pressure Injury



- Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis:

Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARS), or traumatic wounds (skin tears, burns, abrasions).



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---

## Stage 2 Appearance



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---

## Wound Bed Assessment



- Stage 2 pressure ulcers heal by epithelialization (resurfacing), not granulation, therefore the wound base would be described as pink or red versus granulation tissue (impacts MDS 3.0 coding)



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---

### Stage 3 Pressure Injury



• Stage 3 Pressure Injury: Full-thickness skin loss:

Full-thickness loss of skin in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage, and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---

### Stage 3 Pressure Injury



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---

### Stage 4 Pressure Injury



• Stage 4 Pressure Injury: Full-thickness skin and tissue loss

Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---

### Stage 4 Appearance



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

### NPUAP Position Statement (9-27-12)<sup>1</sup>



- Although the presence of visible or palpable cartilage at the base of a pressure ulcer was not included in the stage 4 terminology; it is the opinion of the NPUAP that cartilage serves the same anatomical function as bone. Therefore, pressure ulcers that have exposed cartilage should be classified as a Stage 4.



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

### Unstageable Pressure Injury



- Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss

Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on an ischemic limb or the heel(s) should not be removed.



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

## Unstageable Appearance



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---

## Assessment



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

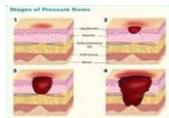
---

---

## Pressure Injury Assessment



- Purpose of staging is for consistent communication of depth of tissue destruction
- Once staged, the injury should not be back staged, rather the wound should be described in terms of size, shape, color, drainage, and odor using one of the wound assessment measures ([www.npuap.com](http://www.npuap.com))



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---



### Section M

#### M0100: Determination of PU Risk

Check ALL that apply

- A. Resident has a stage 1 or greater, a scar over bony prominence, or a non-removable dressing
- B. Formal assessment instrument/tool
  - Braden Scale is listed or "other tools may be used"
- C. Clinical Assessment (head to toe inspection of the skin, observation and medical record review)
- D. None of the above



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---



### Risk Assessment

Clinical assessment, they list the following examples:

- Impaired/decreased mobility and decreased functional ability
- Co-morbid conditions, such as end stage renal disease, thyroid disease, or diabetes
- Drug, such as steroids, that may affect wound healing
- Impaired blood flow



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---



### Risk Assessment

Clinical assessment, they list the following examples:

- Resident refusal of some aspects of care and treatment
- Cognitive impairment
- Urinary and fecal incontinence
- Under nutrition, malnutrition, and hydration deficits; and
- Healed pressure ulcers, especially Stage 3 or 4 which are more likely to have recurrent breakdown



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---



### Section M

#### • **M0150 Risk of Pressure Ulcers – Steps for assessment:**

- based on M0100 above, is the resident at risk for Pressure Ulcer development?
- If the medical record reveals that the resident currently has a Stage I or greater pressure ulcer, a scar over a bony prominence, or non-removable dressing or device, the resident is at risk for worsening or new pressure ulcers.
- Review formal risk assessment tools to determine the resident's "risk score"
- Review components of the clinical assessment conducted for evidence of pressure ulcer risk.

**Code 0. No OR 1. Yes based on a review of the information gathered for M0100**

---

---

---

---

---

---

---

---

---

---



www.seniorprovidersresource.com



### Section M

#### • **M0210 Unhealed Pressure Ulcer(s)**

##### • **Steps for Assessment**

- Review medical record, including skin care flow sheets or other skin tracking forms
- Speak with direct care staff and treatment nurse to confirm conclusions from medical record review
- Examine the resident and determine whether any ulcers are present
- Identify any known or likely unstageable pressure ulcers

---

---

---

---

---

---

---

---

---

---



www.seniorprovidersresource.com



### Section M

#### • **M0210 Unhealed Pressure Ulcer (s)**

- **Code 0, no: if the resident did not have a pressure ulcer in the 7 day look back period. Then skip to items M0300-M0800**
- **Code 1, yes: if the resident had any pressure ulcer (stage 1, 2, 3, 4 or unstageable) in the 7 day look back period. Proceed to Current Number of Unhealed Pressure Ulcers at each stage item (M0300)**

---

---

---

---

---

---

---

---

---

---



www.seniorprovidersresource.com



### Section M

#### • M0210 Unhealed Pressure Ulcer (s) –

##### • Coding Tips

- If an ulcer arises from a combination of factors which are primarily caused by pressure, code as a pressure ulcer
- Oral mucosal ulcers caused by pressure should NOT be coded in section M. These are captured in item L0200C, abnormal mouth tissue.
- If a pressure ulcer is surgically repaired with a flap or graft, it should be coded as a surgical wound, not pressure. If the flap or graft fails, continue to code it as a surgical wound until healed.



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---



### Section M

#### • M0210 Unhealed Pressure Ulcer (s) –

##### • Coding Tips

- Residents with DM can have pressure, venous, arterial or diabetic neuropathic ulcer. The primary etiology should be considered when coding whether the diabetic has an ulcer that is caused by pressure or other factors
- If a resident with DM has a heel ulcer from pressure and the ulcer is present in the 7 day look back period, code 1 and proceed to code items M0300-M0900 as appropriate for the pressure ulcer
- If a resident with DM has an ulcer on the plantar (bottom) surface of the foot closer to the metatarsal and the ulcer is present in the 7 day look-back period, code 0 and proceed to M1040 to code the ulcer as a diabetic foot ulcer.



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---



### Section M

#### • M0210 Unhealed Pressure Ulcer (s) –

##### • Coding Tips

- Scabs and eschar are different both physically and chemically. Eschar is a collection of dead tissue within the wound that is flush with the surface of the wound. A scab is made up of dried blood cells and serum, sits on the top of the skin, and forms over exposed wounds such as wounds with granulating surfaces (like pressure ulcers, lacerations, evulsions, etc). A scab is evidence of wound healing.
- A pressure ulcer that was staged as a 2 and now has a scab indicates it is a healing stage 2, thus staging should not change. Eschar characteristics and the level of damage it causes to tissues is what makes it easy to distinguish from a scab.
- If a resident had a pressure ulcer on the last assessment and it is now healed, complete Healed Pressure Ulcer item (M0900)
- If a resident had a pressure ulcer that healed during the look-back period of the current assessment, but there was no documented pressure ulcer on the prior assessment, code 0



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---



Section M

**M0300: Current Number of Unhealed Pressure Ulcers at Each Stage**

- Number of pressure ulcers at each stage
- Number of these pressure ulcers at each stage that were present on admission/entry or reentry

---

---

---

---

---

---

---

---

---

---



www.seniorprovidersresource.com



Section M

**Steps for completing M0300A-G: Current Number of Unhealed Pressure Ulcers at Each Stage**

**Step 1: Determine Deepest Anatomical Stage**

For each pressure ulcer, determine the deepest anatomical stage. Do not reverse or back stage. Consider current and historical levels of tissue involvement.

1. Observe and palpate the base of any identified pressure ulcers present to determine the anatomic depth of soft tissue damage involved.

---

---

---

---

---

---

---

---

---

---



www.seniorprovidersresource.com



Section M

**Steps for completing M0300A-G: Current Number of Unhealed Pressure Ulcers at Each Stage**

**Step 1: Determine Deepest Anatomical Stage**

2. Ulcer staging should be based on the ulcer's deepest anatomic soft tissue damage that is visible or palpable. If a pressure ulcer's tissues are obscured such that the depth of soft tissue damage cannot be observed, it is considered to be unstageable (see Step 2 below). Review the history of each pressure ulcer in the medical record. If the pressure ulcer has ever been classified at a higher numerical stage than what is observed now, it should continue to be classified at the higher numerical stage. Nursing homes that carefully document and track pressure ulcers will be able to more accurately code this item.

---

---

---

---

---

---

---

---

---

---



www.seniorprovidersresource.com



**Section M**

**Steps for completing M0300A-G: Current Number of Unhealed Pressure Ulcers at Each Stage**

**Step 2.**

- 1. Visualization of the wound bed is necessary for accurate staging.
- 2. Pressure ulcers that have eschar (tan, black, or brown) or slough (yellow, tan, gray, green or brown) tissue present such that the anatomic depth of soft tissue damage cannot be visualized or palpated in the wound bed, should be classified as unstageable, as illustrated at <http://www.npuap.org/wp-content/uploads/2012/03/NPUAP-Unstage2.jpg>



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---



**Section M**

**Steps for completing M0300A-G: Current Number of Unhealed Pressure Ulcers at Each Stage**

**Step 2.**

- 3. If the wound bed is only partially covered by eschar or slough, and the anatomical depth of tissue damage can be visualized or palpated, numerically stage the ulcer, and do not code this as unstageable.
- 4. A pressure ulcer with intact skin that is a suspected deep tissue injury (sDTI) should not be coded as a Stage 1 pressure ulcer. It should be coded as unstageable, as illustrated at <http://www.npuap.org/wp-content/uploads/2012/03/NPUAP-SuspectDTI.jpg>



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---



**Section M**

**Steps for completing M0300A-G: Current Number of Unhealed Pressure Ulcers at Each Stage**

**Step 2.**

- 5. Known pressure ulcers covered by a non-removable dressing/device (e.g., primary surgical dressing, cast) should be coded as unstageable.



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---

### Section M



#### Steps for completing M0300A-G: Current Number of Unhealed Pressure Ulcers at Each Stage

##### Step 3. Determine "Present on Admission"

For each pressure ulcer, determine if the pressure ulcer was present at the time of admission/entry or reentry and not acquired while the resident was in the care of the nursing home. Consider current and historical levels of tissue involvement.

1. Review the medical record for the history of the ulcer.
2. Review for location and stage at the time of admission/entry or reentry.

---

---

---

---

---

---

---

---

---

---



www.seniorprovidersresource.com

### Section M



#### Steps for completing M0300A-G: Current Number of Unhealed Pressure Ulcers at Each Stage

##### Step 3. Determine "Present on Admission"

3. If the pressure ulcer was present on admission/entry or reentry and subsequently increased in numerical stage during the resident's stay, the pressure ulcer is coded at that higher stage, and that higher stage **should not be considered as "present on admission."**
4. If the pressure ulcer was unstageable on admission/entry or reentry, but becomes numerically stageable later, it should be considered as "present on admission" at the stage at which it first becomes numerically stageable. If it subsequently increases in numerical stage, that higher stage **should not be considered "present on admission."**

---

---

---

---

---

---

---

---

---

---



www.seniorprovidersresource.com

### Section M



#### Steps for completing M0300A-G: Current Number of Unhealed Pressure Ulcers at Each Stage

##### Step 3. Determine "Present on Admission"

5. If a resident who has a pressure ulcer that was **originally acquired in the facility** is hospitalized and returns with that pressure ulcer at the same numerical stage, the pressure ulcer **should not be coded as "present on admission"** because it was present and acquired at the facility prior to the hospitalization.

---

---

---

---

---

---

---

---

---

---



www.seniorprovidersresource.com

**Section M**



**Steps for completing M0300A-G: Current Number of Unhealed Pressure Ulcers at Each Stage**

**Step 3. Determine “Present on Admission”**

- 6. If a resident who has a pressure ulcer that was “present on admission” (not acquired in the facility) is hospitalized and returns with that pressure ulcer at the same numerical stage, the pressure ulcer is still coded as “present on admission” because it was originally acquired outside the facility and has not changed in stage.
- 7. If a resident who has a pressure ulcer is hospitalized and the ulcer increases in numerical stage during the hospitalization, it should be coded as “present on admission” at that higher stage upon reentry.



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---

**Section M**



**Steps for completing M0300A-G: Current Number of Unhealed Pressure Ulcers at Each Stage**

M0300E: Unstageable Pressure Ulcers Related to Non-removable Dressing/Device

M0300F: Unstageable Pressure Ulcers Related to Slough and/or Eschar

M0300G: Unstageable Pressure Ulcers Related to Suspected Deep Tissue Injury



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---

**Section M**



**M0610: Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Pressure Ulcer Due to Slough and/or Eschar**

<p><b>M0610. Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar</b>                  Complete only if M0300C1, M0300D1 or M0300F1 is greater than 0.                  If the resident has one or more unhealed Stage 3 or 4 pressure ulcers or an unstageable pressure ulcer due to slough or eschar, identify the pressure ulcer with the largest surface area (length x width) and record in centimeters:</p>	
<input type="text"/> <input type="text"/> <input type="text"/> cm	<p>A. Pressure ulcer length: Longest length from head to toe</p>
<input type="text"/> <input type="text"/> <input type="text"/> cm	<p>B. Pressure ulcer width: Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length</p>
<input type="text"/> <input type="text"/> <input type="text"/> cm	<p>C. Pressure ulcer depth: Depth of the same pressure ulcer from the visible surface to the deepest area (if depth is unknown, enter a dash in each box)</p>



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---

### Measuring the Open Area

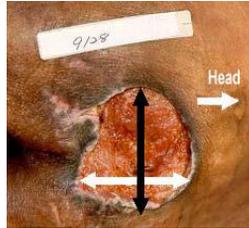
Place the resident in the most appropriate position which will allow for accurate wound measurement.

Measure in centimeters

**Length:** longest length from head to toe

**Width:** Widest width; side-to-side (90-degree angle) to length

**Depth:** From the visible surface to the deepest area



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---



### Section M

#### M0700 Most Severe Tissue Type for Any Pressure Ulcer –

M0700. Most Severe Tissue Type for Any Pressure Ulcer	
Select the best description of the most severe type of tissue present in any pressure ulcer bed	
Enter Code	<ol style="list-style-type: none"> <li>1. <b>Epithelial tissue</b> - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin</li> <li>2. <b>Granulation tissue</b> - pink or red tissue with shiny, moist, granular appearance</li> <li>3. <b>Slough</b> - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous</li> <li>4. <b>Eschar</b> - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin</li> <li>9. <b>None of the Above</b></li> </ol>



www.seniorprovidersresource.com 69

---

---

---

---

---

---

---

---



### Section M

#### M0700 Most Severe Tissue Type for Any Pressure Ulcer –

##### Coding Tips and Special Populations

- Stage 2 pressure ulcers by definition have partial-thickness loss of the dermis. Granulation tissue, slough or eschar are not present in Stage 2 pressure ulcers. Therefore, Stage 2 pressure ulcers should **not** be coded as having granulation, slough or eschar tissue and should be **coded as 1** for this item.
- Code for the most severe type of tissue present in the pressure ulcer wound bed.



www.seniorprovidersresource.com 69

---

---

---

---

---

---

---

---





### Section M

#### M0800 Worsening in Pressure Ulcer Since Prior

##### • Assessment (OBRA or scheduled PPS) or Last Admission/Entry of Re-entry

- If a numerically staged pressure ulcer increases in numerical staging it is considered worsened.
- Coding worsening of unstageable pressure ulcers:
  - If a pressure ulcer was unstageable on admission/entry or reentry, do not consider it to be worsened on the first assessment that it is able to be numerically staged. However, if the pressure ulcer subsequently increases in numerical stage after that assessment, it should be considered worsened.



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---



### Section M

#### M0800 Worsening in Pressure Ulcer Since Prior

##### • Assessment (OBRA or scheduled PPS) or Last Admission/Entry of Re-entry

- If a pressure ulcer was numerically staged and becomes unstageable due to slough or eschar, do not consider this pressure ulcer as worsened. The only way to determine if this pressure ulcer has worsened is to remove enough slough or eschar so that the wound bed becomes visible. Once enough of the wound bed can be visualized and/or palpated such that the tissues can be identified and the wound restaged, the determination of worsening can be made.



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---



### Section M

#### M0800 Worsening in Pressure Ulcer Since Prior

##### • Assessment (OBRA or scheduled PPS) or Last Admission/Entry of Re-entry

- If a pressure ulcer was numerically staged and becomes unstageable, and is subsequently debrided sufficiently to be numerically staged, compare its numerical stage before and after it was unstageable. If the pressure ulcer's current numerical stage has increased, consider this pressure ulcer as worsened.



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---







### Section M

#### M1030: Number of Venous and Arterial Ulcers

##### Arterial Ulcers

- Trophic skin changes (e.g., dry skin, loss of hair growth, muscle atrophy, brittle nails) may also be present. The wound may start with some kind of minor trauma, such as hitting the leg on a wheelchair. The wound does not typically occur over a bony prominence, however, can occur on the tops of the toes. Pressure forces play virtually no role in the development of the ulcer, however, for some residents, pressure may play a part. Ischemia is the major etiology of these ulcers. Lower extremity and foot pulses may be diminished or absent.

---

---

---

---

---

---

---

---

---

---



www.seniorprovidersresource.com 82

### Arterial Insufficiency




---

---

---

---

---

---

---

---

---

---



www.seniorprovidersresource.com

### Arterial Insufficiency



#### Characteristics of Arterial Insufficiency<sup>1</sup>:

- Atrophy of skin, subcutaneous tissue and muscle
- Shiny, taut, thin, dry skin
- Hair loss
- Dystrophic nails




---

---

---

---

---

---

---

---

---

---



www.seniorprovidersresource.com

## Arterial Insufficiency



### Characteristics of Arterial Insufficiency<sup>1</sup>:

- Increased pain with activity and/or elevation (intermittent claudication, resting, nocturnal and positional)



Senior Providers

www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---

## Arterial Insufficiency



### Characteristics of Arterial Insufficiency<sup>1</sup>:

- Purpura



Senior Providers

www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---

## Arterial Insufficiency



### Characteristics of Arterial Insufficiency<sup>1</sup>:

- Perfusion
  - Skin Temperature:
    - Cold/decreased
  - Capillary Refill
    - Delayed – more than 3 seconds
  - Peripheral Pulses
    - Absent or Diminished



Senior Providers

www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

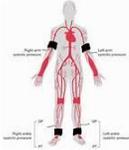
---

## Arterial Insufficiency Tests



### Testing for Arterial Insufficiency<sup>1</sup>:

- **Ankle Brachial Index (ABI)**
  - ≤ 0.9 Arterial Insufficiency
  - ≤ 0.6 to 0.8 Borderline Perfusion
  - ≤ 0.5 Severe Ischemia
  - ≤ 0.4 Critical Ischemia Limb Threatened



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---

## Arterial Insufficiency Tests



### Testing for Arterial Insufficiency<sup>1</sup>:

- **Systolic Toe Pressure**
  - TP < 30mmHg
- **Transcutaneous Oxygen Pressure Measurements (TcPO<sub>2</sub>)**
  - TcPO<sub>2</sub> < 30 mm Hg



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---

## Arterial Insufficiency Ulcers



### Location of Arterial Ulcers<sup>1</sup>

- Toe tips and/or web spaces
- Phalangeal heads
- Over lateral malleolus
- Areas exposed to pressure or repetitive trauma (shoe, cast, brace, etc.)
- Mid-tibia (shin)



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---

## Arterial Insufficiency Ulcers



### Typical Wound Appearance<sup>1</sup>

- "Punched out" appearance
- Dry, pale or necrotic wound base
- Minimal or absent granulation tissue
- Wound size usually small & may be deep
- Minimal exudate
- Gangrene (wet or dry), necrosis common
- Localized edema (may indicate infection)



www.seniorprovidersresource.com




---

---

---

---

---

---

---

---

---

---

## Arterial Insufficiency Ulcers



### Possible complications<sup>1</sup>

Cellulitis



Gangrene



Osteomyelitis



ALBANE

www.seniorprovidersresource.com




---

---

---

---

---

---

---

---

---

---

## Section M



### M1030: Number of Venous and Arterial Ulcers

#### Venous Ulcers

- The wound may start with some kind of minor trauma, such as hitting the leg on a wheelchair. The wound does not typically occur over a bony prominence, and pressure forces play virtually **no** role in the development of the ulcer.



www.seniorprovidersresource.com 93

---

---

---

---

---

---

---

---

---

---

## Venous Insufficiency



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

## Venous Insufficiency



### Lower Leg characteristics<sup>3</sup>

- Edema  
Pitting or non-pitting



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

## Venous Insufficiency



### Lower Leg characteristics<sup>3</sup>

- Venous Dermatitis (erythema, scaling, edema and weeping)



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

## Venous Insufficiency



### Lower Leg characteristics<sup>3</sup>

#### -Hemosiderin Staining

Brown staining (hyperpigmentation)



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

## Venous Insufficiency



### Lower Leg characteristics<sup>3</sup>

#### - Active Cellulitis



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

## Venous Insufficiency



### Characteristics of Venous Insufficiency<sup>3</sup>

#### ▪ Pain

Minimal unless infected or desiccated

#### ▪ Peripheral Pulses

Present/palpable

#### ▪ Capillary Refill

Normal-less than 3 seconds



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

## Venous Insufficiency Ulcers



### Location of Venous Ulcer<sup>3</sup>

- Medial aspect of the lower leg and ankle
- Superior to medial malleolus



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---

## Venous Insufficiency Ulcers



### Typical Wound Appearance<sup>3</sup>

- Wound edges: irregular
- Wound bed: ruddy red, yellow adherent of loose slough, granulation tissue, undermining or tunneling are uncommon, wounds are shallow
- Amount of exudate: mild, moderate to heavy
- Peri-wound skin: macerated, crusty, scaling, hyper-pigmented



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---

## Venous Insufficiency



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---

### Section M

#### M1040 Other Ulcers, Wounds, and Skin

##### Problems

M1040. Other Ulcers, Wounds and Skin Problems	
↓ Check all that apply	
Foot Problems	
<input type="checkbox"/>	A. Infection of the foot (e.g., cellulitis, purulent drainage)
<input type="checkbox"/>	B. Diabetic foot ulcer(s)
<input type="checkbox"/>	C. Other open lesion(s) on the foot
Other Problems	
<input type="checkbox"/>	D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)
<input type="checkbox"/>	E. Surgical wound(s)
<input type="checkbox"/>	F. Burn(s) (second or third degree)
<input type="checkbox"/>	G. Skin tear(s)
<input type="checkbox"/>	H. Moisture Associated Skin Damage (MASD) (e.g., incontinence-associated dermatitis [IAD], perspiration, drainage)
<input type="checkbox"/>	None of the Above
<input type="checkbox"/>	Z. None of the above were present



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---



### Section M

#### M1040 Other Ulcers, Wounds, and Skin

##### Problems

##### Coding Tips

##### M1040B Diabetic Foot Ulcers

- Diabetic neuropathy affects the lower extremities of individuals with diabetes. Individuals with diabetic neuropathy can have decreased awareness of pain in their feet. This means they are at high risk for foot injury, such as burns from hot water or heating pads, cuts or scrapes from stepping on foreign objects, and blisters from inappropriate or tight-fitting shoes. Because of decreased circulation and sensation, the resident may not be aware of the wound.



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---



### Section M

#### M1040 Other Ulcers, Wounds, and Skin Problems

##### Coding Tips

##### M1040B Diabetic Foot Ulcers

- Neuropathy can also cause changes in the structure of the bones and tissue in the foot. This means the individual with diabetes experiences pressure on the foot in areas not meant to bear pressure. Neuropathy can also cause changes in normal sweating, which means the individual with diabetes can have dry, cracked skin on his other foot.



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---

**Section M**



**M1040 Other Ulcers, Wounds, and Skin**

**Problems**

**Coding Tips**

**M1040B Diabetic Foot Ulcers**

- Do **not** include pressure ulcers that occur on residents with diabetes mellitus here. For example, an ulcer caused by pressure on the heel of a diabetic resident is a pressure ulcer and not a diabetic foot ulcer.

---

---

---

---

---

---

---

---

---

---



www.seniorprovidersresource.com

**Section M**



**M1040 Other Ulcers, Wounds, and Skin**

**Problems**

**Coding Tips**

**M1040D Open Lesion Other than Ulcers, Rashes, Cuts**

- Do **not** code rashes or cuts/lacerations here. Although not recorded on the MDS assessment, these skin conditions should be considered in the plan of care.

---

---

---

---

---

---

---

---

---

---



www.seniorprovidersresource.com

**Section M**



**M1040 Other Ulcers, Wounds, and Skin**

**Problems**

**Coding Tips**

**M1040E Surgical Wounds**

- This category does not include healed surgical sites and healed stomas or lacerations that require suturing or butterfly closure as surgical wounds. PICC sites, central line sites, and peripheral IV sites are not coded as surgical wounds.
- Surgical debridement of a pressure ulcer does not create a surgical wound. Surgical debridement is used to remove necrotic or infected tissue from the pressure ulcer in order to facilitate healing. A pressure ulcer that has been surgically debrided should continue to be coded as a pressure ulcer.

---

---

---

---

---

---

---

---

---

---



www.seniorprovidersresource.com

Section M



M1040 Other Ulcers, Wounds, and Skin

Problems

Coding Tips

M1040E Surgical Wounds

- Code pressure ulcers that require surgical intervention for closure with graft and/or flap procedures in this item (e.g., excision of pressure ulcer with myocutaneous flap). Once a pressure ulcer is excised and a graft and/or flap is applied, it is no longer considered a pressure ulcer, but a surgical wound



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---

Section M



M1040 Other Ulcers, Wounds, and Skin

Problems

Coding Tips

M1040F Burns (Second or Third Degree)

- Do **not** include first degree burns (changes in skin color only).

M1040G Skin Tear(s)

- Skin tears are a result of shearing, friction or trauma to the skin that causes a separation of the skin layers. They can be partial or full thickness. Code all skin tears in this item, even if already coded in Item J1900B.



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---

Section M



M1040 Other Ulcers, Wounds, and Skin

Problems

Coding Tips

M1040H Moisture Associated Skin Damage (MASD)

- Moisture associated skin damage (MASD) is a result of skin damage caused by moisture rather than pressure. It is caused by sustained exposure to moisture which can be caused, for example, by incontinence, wound exudate and perspiration. It is characterized by inflammation of the skin, and occurs with or without skin erosion and/or infection. MASD is also referred to as incontinence-associated dermatitis and can cause other conditions such as intertriginous dermatitis, periwound moisture-associated dermatitis, and peristomal moisture-associated dermatitis. Provision of optimal skin care and early identification and treatment of minor cases of MASD can help avoid progression and skin breakdown.



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---





**Section M**

**M1200 (A – Z) Skin and Ulcer Treatments - Coding Tips**

**M1200A/M1200B Pressure Reducing Devices**

- Pressure reducing devices redistribute pressure so that there is some relief on or near the area of the ulcer. The appropriate reducing (redistribution) device should be selected based on the individualized needs of the resident.
- Do **not** include egg crate cushions of any type in this category.
- Do **not** include doughnut or ring devices in chairs.



[www.seniorprovidersresource.com](http://www.seniorprovidersresource.com)

---

---

---

---

---

---

---

---

---

---



**Section M**

**M1200 (A – Z) Skin and Ulcer Treatments - Coding Tips**

**M1200C Turning/Repositioning Program**

- The turning/repositioning program is specific as to the approaches for changing the resident’s position and realigning the body. The program should specify the intervention (e.g., reposition on side, pillows between knees) and frequency (e.g., every 2 hours).
- Progress notes, assessments, and other documentation (as dictated by facility policy) should support that the turning/repositioning program is monitored and reassessed to determine the effectiveness of the intervention.



[www.seniorprovidersresource.com](http://www.seniorprovidersresource.com)

---

---

---

---

---

---

---

---

---

---



**Section M**

**M1200 (A – Z) Skin and Ulcer Treatments - Coding Tips**

**M1200D Nutrition or Hydration Intervention to Manage Skin Problems**

- The determination as to whether or not one should receive nutritional or hydration interventions for skin problems should be based on an individualized nutritional assessment. The interdisciplinary team should review the resident’s diet and determine if the resident is taking in sufficient amounts of nutrients and fluids or are already taking supplements that are fortified with the US Recommended Daily Intake (US RDI) of nutrients.



[www.seniorprovidersresource.com](http://www.seniorprovidersresource.com)

---

---

---

---

---

---

---

---

---

---



**Section M**

**M1200 (A – Z) Skin and Ulcer Treatments - Coding Tips**

**M1200D Nutrition or Hydration Intervention to Manage Skin Problems**

- Additional supplementation above the US RDI has not been proven to provide any further benefits for management of skin problems including pressure ulcers. Vitamin and mineral supplementation should only be employed as an intervention for managing skin problems, including pressure ulcers, when nutritional deficiencies are confirmed or suspected through a thorough nutritional assessment (AMDA PU Guideline, page 6).



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---



**Section M**

**M1200 (A – Z) Skin and Ulcer Treatments - Coding Tips**

**M1200D Nutrition or Hydration Intervention to Manage Skin Problems**

- If it is determined that nutritional supplementation, i.e. adding additional protein, calories, or nutrients is warranted, the facility should document the nutrition or hydration factors that are influencing skin problems and/or wound healing and “tailor nutritional supplementation to the individual’s intake, degree of under-nutrition, and relative impact of nutrition as a factor overall; and obtain dietary consultation as needed,” (AMDA PU Therapy Companion, page 4).



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---



**Section M**

**M1200 (A – Z) Skin and Ulcer Treatments - Coding Tips**

**M1200D Nutrition or Hydration Intervention to Manage Skin Problems**

- It is important to remember that additional supplementation is not automatically required for pressure ulcer management. Any interventions should be specifically tailored to the resident’s needs, condition, and prognosis (AMDA PU Therapy Companion, page 11).



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---



**Section M**

**M1200 (A – Z) Skin and Ulcer Treatments - Coding Tips**

**M1200E Pressure Ulcer Care**

- Pressure ulcer care includes **any** intervention for treating pressure ulcers coded in **Current Number of Unhealed Pressure Ulcers at Each Stage (M0300A-G)**. Examples may include the use of topical dressings, enzymatic, mechanical or surgical debridement, wound irrigations, negative pressure wound therapy (NPWT), and/or hydrotherapy.



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---



**Section M**

**M1200 (A – Z) Skin and Ulcer Treatments - Coding Tips**

**M1200F Surgical Wound Care**

- Does not include post-operative care following eye or oral surgery.



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---



**Section M**

**M1200 (A – Z) Skin and Ulcer Treatments - Coding Tips**

**M1200F Surgical Wound Care**

- Surgical debridement of a pressure ulcer does not create a surgical wound. Surgical debridement is used to remove necrotic or infected tissue from the pressure ulcer in order to facilitate healing, and thus, any wound care associated with pressure ulcer debridement would be coded in **M1200E, Pressure Ulcer Care**. The only time a surgical wound would be created is if the pressure ulcer itself was excised and a flap and/or graft used to close the pressure ulcer.



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---



**Section M**

**M1200 (A – Z) Skin and Ulcer Treatments - Coding Tips**

**M1200F Surgical Wound Care**

- Surgical wound care may include any intervention for treating or protecting any type of surgical wound. Examples may include topical cleansing, wound irrigation, application of antimicrobial ointments, application of dressings of any type, suture/staple removal, and warm soaks or heat application.



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---



**Section M**

**M1200 (A – Z) Skin and Ulcer Treatments - Coding Tips**

**M1200F Surgical Wound Care**

- Surgical wound care for pressure ulcers that require surgical intervention for closure (e.g., excision of pressure ulcer with flap and/or graft coverage) can be coded in this item, as once a pressure ulcer is excised and flap and/or graft applied, it is no longer considered a pressure ulcer, but a surgical wound.



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---



**Section M**

**M1200 (A – Z) Skin and Ulcer Treatments - Coding Tips**

**M1200G Application of Non-surgical Dressings (with or without Topical Medications) Other than to Feet**

- Do **not** code application of non-surgical dressings for pressure ulcer(s) other than to feet in this item; use **M1200E, Pressure Ulcer Care**.
- Dressings do not have to be applied daily in order to be coded on the MDS assessment. If any dressing meeting the MDS definitions was applied even once during the 7-day look-back period, the assessor should check that MDS item.



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---



**Section M**

**M1200 (A – Z) Skin and Ulcer Treatments - Coding Tips**

**M1200G Application of Non-surgical Dressings (with or without Topical Medications) Other than to Feet**

- This category may include but is not limited to: dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles used to treat a skin condition, compression bandages, etc. Non-surgical dressings do not include adhesive bandages (e.g., BAND- AID® bandages).



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---



**Section M**

**M1200 (A – Z) Skin and Ulcer Treatments - Coding Tips**

**M1200H Application of Ointments/Medications Other than to Feet**

- Do **not** code application of ointments/medications (e.g., chemical or enzymatic debridement) for pressure ulcers here; use **M1200E, Pressure Ulcer Care**.
- This category may include ointments or medications used to treat a skin condition (e.g., cortisone, antifungal preparations, chemotherapeutic agents).



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---



**Section M**

**M1200 (A – Z) Skin and Ulcer Treatments - Coding Tips**

**M1200H Application of Ointments/Medications Other than to Feet**

- Ointments/medications may include topical creams, powders, and liquid sealants used to treat or prevent skin conditions.
- This category does not include ointments used to treat non-skin conditions (e.g., nitropaste for chest pain, testosterone cream).



www.seniorprovidersresource.com

---

---

---

---

---

---

---

---

---

---



**Section M**

**M1200 (A – Z) Skin and Ulcer Treatments - Coding Tips**

**M1200I Application of Dressings to the Feet (with or without Topical Medications)**

- Includes interventions to treat any foot wound or ulcer **other than a pressure ulcer.**
- Do **not** code application of dressings to pressure ulcers on the foot, use **M1200E, Pressure Ulcer Care.**
- Do not code application of dressings to the ankle. The ankle is not considered part of the foot.



www.seniorprovidersresource.com

---



---



---



---



---



---



---



---

**THANK YOU**



**Jeri Ann Lundgren, RN, BSN, PHN, CWS, CWCN, CPT**

**Cell: 612-805-9703**

**[jeri@seniorprovidersresource.com](mailto:jeri@seniorprovidersresource.com)**



www.seniorprovidersresource.com

---



---



---



---



---



---



---



---